(2) For an application submitted on or after October 15, 2014, the Exchange may adopt an exemption eligibility determination made by HHS, provided that—

(i) The Exchange accepts the application, as specified in §155.610(c), and issues the eligibility notice, as specified in §155.610(i);

(ii) Verifications and other activities required in connection with eligibility determinations for exemptions are performed by the Exchange in accordance with the standards identified in this subpart or by HHS in accordance with the agreement described in paragraph (b)(2)(v) of this section;

(iii) The Exchange transmits to HHS promptly and without undue delay and via secure electronic interface, all information provided as a part of the application or update that initiated the eligibility determination, and any information obtained or verified by the Exchange;

(iv) The Exchange adheres to the eligibility determination made by HHS; and

(v) The Exchange and HHS enter into an agreement specifying their respective responsibilities in connection with eligibility determinations for exemptions.

§155.630 Reporting.

Requirement to provide information related to tax administration. If the Exchange grants an individual a certificate of exemption in accordance with §155.610(i), the Exchange must transmit to the IRS at such time and in such manner as the IRS may specify—

(a) The individual's name, Social Security number, and exemption certificate number;

(b) Any other information required in guidance published by the Secretary of the Treasury in accordance with 26 CFR 601.601(d)(2).

§155.635 Right to appeal.

(a) For an application submitted before October 15, 2014, the Exchange must include the notice of the right to appeal and instructions regarding how to file an appeal in any notification issued in accordance with §155.610(i).

(b) For an application submitted on or after October 15, 2014, the Exchange must include the notice of the right to appeal and instructions regarding how to file an appeal in any notification issued in accordance with §155.610(i) and §155.625(b)(2)(i).

Subpart H—Exchange Functions: Small Business Health Options Program (SHOP)

SOURCE: 77 FR 18464, Mar. 27, 2012, unless otherwise noted.

§155.700 Standards for the establishment of a SHOP.

(a) *General requirement.* An Exchange must provide for the establishment of a SHOP that meets the requirements of this subpart and is designed to assist qualified employers and facilitate the enrollment of qualified employees into qualified health plans.

(b) *Definition.* For the purposes of this subpart:

Group participation rule means a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer.

SHOP application filer means an applicant, an authorized representative, an agent or broker of the employer, or an employer filing for its employees where not prohibited by other law.

[77 FR 18464, Mar. 27, 2012, as amended at 78 FR 54141, Aug. 30, 2013]

§155.705 Functions of a SHOP.

(a) *Exchange functions that apply to SHOP.* The SHOP must carry out all the required functions of an Exchange described in this subpart and in subparts C, E, and K of this part, except:

(1) Requirements related to individual eligibility determinations in subpart D of this part;

(2) Requirements related to enrollment of qualified individuals described in subpart E of this part;

(3) The requirement to issue certificates of exemption in accordance with §155.200(b); and

(4) Requirements related to the payment of premiums by individuals, Indian tribes, tribal organizations and

urban Indian organizations under §155.240.

(b) *Unique functions of a SHOP.* The SHOP must also provide the following unique functions:

(1) *Enrollment and eligibility functions.* The SHOP must adhere to the requirements outlined in §§155.710, 155.715, 155.720, 155.725, and 155.730.

(2) *Employer choice requirements.* With regard to QHPs offered through the SHOP for plan years beginning on or after January 1, 2015, the SHOP must allow a qualified employer to select a level of coverage as described in section 1302(d)(1) of the Affordable Care Act, in which all QHPs within that level are made available to the qualified employees of the employer.

(3) *SHOP options with respect to employer choice requirements.* (i) For plan years beginning before January 1, 2015, a SHOP may allow a qualified employer to make one or more QHPs available to qualified employees:

(A) By the method described in paragraph (b)(2) of this section, or

(B) By a method other than the method described in paragraph (b)(2) of this section.

(ii) For plan years beginning on or after January 1, 2015, a SHOP:

(A) Must allow an employer to make available to qualified employees all QHPs at the level of coverage selected by the employer as described in paragraph (b)(2) of this section, and

(B) May allow an employer to make one or more QHPs available to qualified employees by a method other than the method described in paragraph (b)(2) of this section.

(iii) For plan years beginning before January 1, 2015, a Federally-facilitated SHOP will provide a qualified employer the choice to make available to qualified employees a single QHP.

(iv) For plan years beginning on or after January 1, 2015, a Federally-facilitated SHOP will provide a qualified employer a choice of two methods to make QHPs available to qualified employees:

(A) The employer may choose a level of coverage as described in paragraph (b)(2) of this section, or

(B) The employer may choose a single QHP.

(4)(i) *Premium aggregation.* Consistent with the effective dates set forth in paragraph (b)(4)(ii) of this section, the SHOP must perform the following functions related to premium payment administration:

(A) Provide each qualified employer with a bill on a monthly basis that identifies the employer contribution, the employee contribution, and the total amount that is due to the QHP issuers from the qualified employer;

(B) Collect from each employer the total amount due and make payments to QHP issuers in the SHOP for all enrollees; and

(C) Maintain books, records, documents, and other evidence of accounting procedures and practices of the premium aggregation program for each benefit year for at least 10 years.

(ii) *Effective dates.* (A) A State-based SHOP may elect to perform these functions for plan years beginning before January 1, 2015, but need not do so.

(B) A Federally-facilitated SHOP will perform these functions only in plan years beginning on or after January 1, 2015.

(5) *QHP Certification.* With respect to certification of QHPs in the small group market, the SHOP must ensure each QHP meets the requirements specified in §156.285 of this subchapter.

(6) *Rates and rate changes.* The SHOP must—

(i) Require all QHP issuers to make any change to rates at a uniform time that is either quarterly, monthly, or annually; and

(ii) Prohibit all QHP issuers from varying rates for a qualified employer during the employer's plan year.

(7) *QHP availability in merged markets.* If a State merges the individual market and the small group market risk pools in accordance with section 1312(c)(3) of the Affordable Care Act, the SHOP may permit a qualified employee to enroll in any QHP meeting the following requirements of the small group market:

(i) Deductible maximums described in section 1302(c) of the Affordable Care Act; and

(ii) Levels of coverage described in section 1302(d) of the Affordable Care Act.

(8) *QHP availability in unmerged markets.* If a State does not merge the individual and small group market risk pools, the SHOP must permit each qualified employee to enroll only in QHPs in the small group market.

(9) *SHOP expansion to large group market.* If a State elects to expand the SHOP to the large group market, a SHOP must allow issuers of health insurance coverage in the large group market in the State to offer QHPs in such market through a SHOP beginning in 2017 provided that a large employer meets the qualified employer requirements other than that it be a small employer.

(10) *Participation rules.* Subject to §147.104 of this subchapter, the SHOP may authorize uniform group participation rules for the offering of health insurance coverage in the SHOP. If the SHOP authorizes a minimum participation rate, such rate must be based on the rate of employee participation in the SHOP, not on the rate of employee participation in any particular QHP or QHPs of any particular issuer.

(i) Subject to §147.104 of this subchapter, a Federally-facilitated SHOP must use a minimum participation rate of 70 percent, calculated as the number of qualified employees accepting coverage under the employer's group health plan, divided by the number of qualified employees offered coverage, excluding from the calculation any employee who, at the time the employer submits the SHOP application, is enrolled in coverage through another employer's group health plan or through a governmental plan such as Medicare, Medicaid, or TRICARE.

(ii) Notwithstanding paragraph (b)(10)(i) of this section, a Federally-facilitated SHOP may utilize a different minimum participation rate in a State if there is evidence that a State law sets a minimum participation rate or that a higher or lower minimum participation rate is customarily used by the majority of QHP issuers in that State for products in the State's small group market outside the SHOP.

(11) *Premium calculator.* In the SHOP, the premium calculator described in §155.205(b)(6) must facilitate the comparison of available QHPs after the application of any applicable employer contribution in lieu of any advance payment of the premium tax credit and any cost sharing reductions.

(i) To determine the employer and employee contributions, a SHOP may establish one or more standard methods that employers may use to define their contributions toward employee and dependent coverage.

(ii) A Federally-facilitated SHOP must use the following method for employer contributions:

(A) The employer will select a level of coverage as described in paragraph (b)(2) and (b)(3) of this section.

(B) The employer will select a QHP within that level of coverage to serve as a reference plan on which contributions will be based.

(C) The employer will define a percentage contribution toward premiums for employee-only coverage under the reference plan and, if dependent coverage is offered, a percentage contribution toward premiums for dependent coverage under the reference plan.

(D) Either State law or the employer may require that a Federally-facilitated SHOP base contributions on a calculated composite premium for the reference plan for employees, for adult dependents, and for dependents below age 21.

(E) The resulting contribution amounts for each employee's coverage may then be applied toward the QHP selected by the employee.

(c) *Coordination with individual market Exchange for eligibility determinations.* A SHOP must provide data related to eligibility and enrollment of a qualified employee to the individual market Exchange that corresponds to the service area of the SHOP, unless the SHOP is operated pursuant to §155.100(a)(2).

(d) *Duties of Navigators in the SHOP.* In States that have elected to operate only a SHOP pursuant to §155.100(a)(2), at State option and if State law permits the Navigator duties described in §155.210(e)(3) and (4) may be fulfilled through referrals to agents and brokers.

[77 FR 18444, Mar. 27, 2012, as amended at 78 FR 15533, Mar. 11, 2013; 78 FR 33239, June 4, 2013; 78 FR 54141, Aug. 30, 2013]